

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/13/2014	
NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints #IN00144111 and #IN00144052 completed on 2-13-14.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 1-15-14</p> <p>Complaint #IN00144111 - Corrected Complaint #IN00144052 - Corrected</p> <p>Survey dates: March 11 and 13, 2014</p> <p>Facility number: 00491 Provider number: 155495 AIM number: 100291230</p> <p>Survey Team: Debora Kammeyer, RN-TC Lora Swanson, RN Julie Wagoner, RN</p> <p>Census Bed Type: SNF: 9 SNF/NF: 42 Total: 51</p> <p>Census Payor Type: Medicare : 7 Medicaid: 34 Private: 10 Total: 51</p> <p>Sample: 6</p> <p>Lakeland Rehabilitation and Healthcare Center was found to be in compliance with 42 CFR Part</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the investigation of Complaints #IN00144111 and #IN00144052. Quality Review completed on March 17, 2014, by Brenda Meredith, R.N.	{F 000}			